v. The Office of Management and Budget Circular A-87 will be used for determining reasonable costs.

k. Assure that no fee is charged by ODMH or the ADAMH/CMH Boards to the CMH agencies for any cost associated with transferring of funds, contracting, or administrative fees.

l. Assure that no capitation-like payment arrangement between ADAMH/CMH Boards and providers is applied to Medicaid funds. Additionally, assure that no payment arrangements between ADAMH/CMH Boards and providers applicable to non-Medicaid services function in any manner, directly or indirectly, to put Medicaid expenses or revenues at risk or to otherwise limit consumers' access to or use of Medicaid services or to limit payments to CMH agencies for such services.

m. Review current Medicaid rate reconciliation methods with ODHS to ensure that Medicaid pays no more than the actual cost of services provided to Medicaid consumers and also to ensure that such methods are uniformly applied in each Board area. Additionally, ensure that the reconciliation methods for non-Medicaid services do not limit, directly or indirectly, payments to CMH agencies for Medicaid services.

n. Jointly with ODHS, establish a procedure for identifying duplicate service delivery between CMH agencies and HICs and between CMH agencies and providers paid directly by ODHS. Additionally, CMH agencies shall not bill both ODMH and ODHS for a single service event.

o. Assure that services claimed for reimbursement under any other federal program cannot be charged to Title XIX. This exclusion does not apply to persons eligible for Medicare crossover. A CMH agency or subcontractor cannot be reimbursed by ODHS for services reimbursed by ODMH under provisions of this contract.

p. Submit on a quarterly basis a two-year estimate of ODMH anticipated expenditures. Sixty days prior to the start of a quarter, ODMH must give ODHS a monthly estimate for that quarter and a quarterly estimate for the next seven quarters. Failure to submit the two-year projection on a quarterly basis will result in reimbursement being withheld for that quarter until the projection is received. The report must be sent to ODHS, Office of the Budget, 30 East Broad Street, 30th Floor, Columbus, Ohio 43215.

2. **Inpatient Psychiatric Hospitals**

a. Remit to the private psychiatric hospital provider 100% of the Medicaid payment per discharge as determined in accordance with paragraph III B. 2.a.

b. Submit to ODHS Claim Processing Section within 365 days of the date of service, claims for inpatient psychiatric services provided by public psychiatric hospitals.

c. Assume responsibility for 100% of the Medicaid payment for Medicare Part A- Inpatient and Part B- Ancillary crossover claims for services rendered to Medicare/Medicaid-eligible individuals by private psychiatric hospitals, in accordance with paragraph III. B. 2.a.

d. Certify as Medicaid reimbursable the expenditures for public and private psychiatric hospital services. In order to meet the state's requirements for claiming federal funds, payments for public psychiatric hospital services will be made from the ODMH Fund 4x5 ALI 333-607 for only the FFP share. No further payments will made for the same services. ODMH will certify the state share, and will provide the required state match for inpatient psychiatric hospital services.

e. Process inquiries regarding the status of claims in accordance with OAC rule 5101:3-1-199

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and respond as appropriate to the provider.

f. Ensure that all necessary financial, statistical and related records (which shall be available to ODHS, HHS, and other state and federal agencies having authority to audit these records) supporting the expenditures for services rendered to recipients are maintained for a period of six years from remittance of payment, or until an audit is completed and all exceptions resolved.

g. Make records available upon request from ODHS, HHS or designee for audit purposes.

h. Provide ODHS with any data required for HCFA reports related to inpatient hospital services.

i. Submit to ODHS Claims Processing Section, within 365 days from the date of service, claims for physician services provided to Medicaid recipients in public psychiatric hospitals.

j. Make IMD-DSH payments to private psychiatric hospitals that qualify for IMD-DSH adjustments in accordance with rule 5101:3-2-10 of the OAC.

3. **Managing Behavioral Health Services**

a. ODMH may bill for administrative costs incurred in the administration of this program if the following conditions are met:

i. Only direct costs can be claimed for full-time employees and/or for costs claimed under contract.

ii. Prior federal approval is obtained for indirect costs claimed under the contract including data processing expenses associated with the processing of claims submitted for participating mental health and alcohol and other drug addiction programs in accordance with federal regulations and MMIS requirements.

iii. Sufficient documentation must be submitted to ODHS with the billing to justify the amount.

V.
COMPENSATION

A. ODHS agrees to reimburse ODMH, upon proper invoicing and preparation of an Intra-State Transfer Voucher the current FFP for services provided in accordance with Chapter 5101:3-30 of the Administrative Code. Total amount of FFP reimbursement shall not exceed $192,000,000 for FY 00 and $192,000,000 for FY 01 . Such reimbursements shall occur after receipt of FFP from HCFA by ODHS.

B. Payments for any and all services provided pursuant to this agreement are contingent upon the availability of state funds under the Medicaid program. If the Ohio General Assembly, the federal government, or any other source at any time disapproves or ceases to continue funding ODHS or ODMH for payments due hereunder, this agreement is terminated as of the date funding expires without notice or further obligation of ODHS except that ODHS will, subsequent to termination, provide written notice in accordance with Article VI, B.2.

C. All obligations in this agreement are subject to the requirements of Section 126.07 of the Ohio Revised Code.

D. All obligations in this agreement are further subject to approval by HCFA. If ODHS receives notice that the agreement is not approved, both parties agree to work diligently to comply with HCFA requirements. If not able to meet them, the ODHS may terminate this agreement.

VI.

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GENERAL PROVISIONS

A. Effective Dates

This agreement will become effective on July 1, 1999 and will remain in effect until June 30, 2001, subject to the cancellation provisions contained in this agreement.

B. Termination by Notice

1. This agreement may be terminated by either party upon 30 days written notice of termination to the other party. Notice of termination shall be sent or otherwise delivered to the following persons: if ODMH is terminating the agreement, to Director, Ohio Department of Human Services, 30 East Broad Street, 32nd Floor, Columbus, Ohio 43266-0423; or, if ODHS intends to terminate the agreement, to Director, Ohio Department of Mental Health, 30 East Broad Street, 8th Floor, Columbus, Ohio 43266-0414.

2. This agreement may be terminated immediately in the event there is a loss of funding, disapproval by a federal administrative agency, or upon discovery of non-compliance with any federal or state laws, rules or regulations. In the event termination is pursuant to this paragraph B.2., a notice specifying the reasons for termination shall be sent as soon as possible after the termination in accordance with the procedures set forth in Article VI., paragraph B.1.

C. Breach and Default

Upon breach or default of any of the provisions, obligations, or duties embodied in this agreement, the parties may exercise any administrative contractual, equitable, or legal remedies available, without limitation. The waiver or any occurrence of breach or default is not waiver of such subsequent occurrences, and the parties retain the right to exercise all remedies mentioned herein.

D. Amendments

This agreement may be modified or amended provided that any such modification or amendment is in writing and is signed by the directors of the agencies. It is agreed, however, that any amendments to laws, rules, or regulations cited herein will result in the correlative modification of this agreement, without the necessity for executing written amendment.

E. Equal Employment Opportunity

In carrying out this Agreement, the ODMH shall not discriminate against any employee or applicant for employment because of race, religion, national origin, ancestry, color, sex, sexual orientation, age, disability, or Vietnam-era veteran status. The ODMH shall ensure that applicants are hired, and that employees are treated during employment without regard to their race, religion, national origin, ancestry, color, sex, sexual orientation, age, disability, or Vietnam-era veteran status. Such action shall include, but not be limited to the following: Employment, Upgrading, Demotion, or Transfer; Recruitment or Recruitment Advertising; Layoff or Termination; Rates of Pay or other forms of Compensation; and Selection for Training including Apprenticeship.

The ODMH agrees to post in conspicuous places, available to employees and applicants for employment, notices stating that the ODMH complies with all applicable federal and state non-discrimination laws. The ODMH shall, in all solicitations or advertisements for employees placed by or on behalf of the ODMH, state that all qualified applicants shall receive consideration for employment without regard to race, religion, color, sex, national origin, ancestry, sexual orientation, Vietnam-era veteran status, disability or age. The ODMH shall incorporate the foregoing requirements of this paragraph in all of its Contracts for any of the work prescribed herein, and shall require all of its subcontractors for any part of such work to incorporate such requirements in all subcontracts for such work.

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F. Confidentiality of Information

The parties agree that they shall not use any information, systems, or records made available to either party for any purpose other than to fulfill the obligations specified herein. The parties agree to be bound by the same standards of confidentiality that apply to the employees of either party and the State of Ohio. The terms of this section shall be included in any subcontracts executed by either party for work under this agreement. ODMH specifically agrees to comply with state and federal confidentiality laws and regulations applicable to the programs under which this agreement is funded which include, but are not limited to, 42 CFR 431.300 through 42 CFR 431.306. ODMH is responsible for obtaining copies of all ODHS rules governing confidentiality and for assuring compliance with the rules by employees and contractors of ODMH.

G. Compliance with Federal and State Laws, Rules and Regulations

ODMH agrees to comply with all federal and state laws, rules, regulations, and auditing standards which are applicable to the performance of this agreement.

H. Partial Invalidity

A judicial or administrative finding, order, or decision that any part of this agreement is illegal or invalid shall not invalidate the remainder of the agreement.

I. Records Retention

All records relating to costs, work performed and supporting documentation for invoices submitted to ODHS by ODMH along with copies of all deliverables submitted to ODHS pursuant to this agreement shall be retained and made available by ODMH for audit by the State of Ohio (including, but not limited to ODHS, the Auditor of State of Ohio, Inspector General or duly authorized law enforcement officials) and agencies of the United States government for a minimum of three years after final payment under this agreement. If an audit is initiated during this time period, ODMH shall retain such records until the audit is concluded and all issues resolved.

J. Audit Exceptions

1. ODHS shall be responsible for receiving, replying to, and arranging compliance with any audit exception found by any state or federal audit of this Agreement as it pertains to federal or ODHS funding of the Agreement. ODHS shall timely notify ODMH of any adverse findings which allegedly are the fault of ODMH. Upon receipt of notification by ODHS, ODMH shall fully cooperate with ODHS and timely prepare and send to ODHS its written response to the audit exception.

2. ODMH shall be liable for any audit exception that results from its acts or omissions in the performance of this agreement. ODHS shall be liable for any audit exception that results from its acts or omissions in the performance of this agreement. In the event of a dispute concerning the allocation of financial liability for audit exceptions, the parties agree that the dispute shall be referred to the Office of the Governor for a final, binding determination which allocates financial liability.

3. For the purpose of this section, the term "audit exception" shall include federal disallowances and deferrals.

K. Liability Requirements (other than audit)

To the extent allowable by law, agency agrees to hold the other agency harmless from liability, suits, losses, judgments, damages or other demands brought as a result of its actions or omissions in performance of this agreement. However, in the event that an agency is subject to liability, suits, losses, judgments, damages or other demands which are due to the acts or omissions of the other agency, the other agency will not be held harmless.

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L. Resolution of Disputes

The agencies agree that the directors of the agencies shall resolve any disputes between the agencies concerning responsibilities under or performance of any of the terms of this agreement. In the event the directors cannot agree to an appropriate resolution to the disputes they shall be referred to the Office of the Governor for a final, binding determination resolving the dispute.

M. Child Support Enforcement

ODMH agrees to cooperate with ODHS and any Ohio Child Support Enforcement Agency (CSEA) in ensuring employees of ODMH meet child support obligations established under state law. Further, by executing this agreement, ODMH certifies present and future compliance with any court order for the withholding of support which is issued pursuant to sections 3113.21 to 3113.217 of the Ohio Revised Code.

N. Drug-Free Workplace

By executing this agreement, ODMH certifies and affirms that, as applicable to the ODMH, any subcontractor and/or independent contractor, including all field staff associated with the project agree to comply with all applicable state and federal laws regarding a drug-free workplace. The ODMH shall make a good faith effort to ensure that all ODMH employees, while working on State, county or private property, will not purchase, transfer, use or possess illegal drugs or alcohol or abuse prescription drugs in any way.

O. Public Assistance Work Program Participants

By executing this agreement, ODMH agrees to cooperate with ODHS and each County Department of Human Services in providing employment and other work opportunities for recipients of assistance under Chapter 5107 of the Revised Code and recipients of food stamps who are required by law to obtain employment or participate in a work program activity.

P. Entirety of Agreement

All terms and conditions of this agreement are embodied herein. No other terms and conditions will be considered a part of this agreement unless expressly agreed upon in writing and signed by both parties.

APPROVED BY:

Jacqueline Romer-Sensky

JACQUELINE ROMER-SENSKY
Director
Ohio Department of Human Services
30 East Broad Street, 32nd Floor
Columbus, Ohio 43266-0423

DATE: 8-31-99

MICHAEL F. HOGAN, Ph.D.
Director
Ohio Department of Mental Health
30 East Broad Street, 8th Floor
Columbus, Ohio 43266-0414

DATE: 8/23/99

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Attachment 4.16-I

George V. Voinovich
Governor

Arnold R. Tompkins
Director

Ohio Department of Human Services

PROVIDER RELATIONS SECTION
P.O. Box 1461, Columbus, Ohio 43266-0161
950-5627 then dial (8-3288)

Dear Provider of Medical Services:

This form is an application/agreement for enrollment in the Ohio Medicaid program as a medical organization. An organization must have a provider agreement signed by an authorized agent of that organization to be an active Ohio Medicaid provider. Medicaid reimbursement is contingent upon a valid provider agreement being in effect while the services were provided.

Each section of the application contains specific instructions for completion and may require you to attach specific information. Read each section carefully as instructions and requirements may vary for different types of organizations. If there are blocks on the application that are not applicable to your organization, then leave those particular areas blank. **However, incomplete applications or completed applications without required attachments will be returned to you for correction.** Upon completion of the application, an authorized agent or representative of the organization is to read, sign, and date the provider agreement portion of this form. Should this area be left unsigned or undated your application for enrollment will be considered incomplete and will be returned to you for completion. Properly completed applications will be processed and you will be notified by mail of your Medicaid provider status.

The department will deny a provider application/agreement for reasons including, but not limited to:

*Any license, permit, or certificate that is required by the department has been denied, suspended, revoked or not renewed.

*The provider is terminated, suspended or excluded by the Medicare program and/or by the federal Department of Health and Human Services and that action is binding on the provider's participation in the Medicaid program or renders federal financial participation unavailable for the provider's participation in the Medicaid program.

*The organization's owner, officer, authorized agent, associate, manager, or employee has pled guilty to, or been convicted of a criminal activity materially related to either the Medicare or Medicaid program.

*A judgement has been entered in either a criminal or civil action against a Medicaid provider or it's owner, officer, authorized agent, associate, manager, or employee in an action brought pursuant to Section 109.85 of the Revised Code.

The provider agreement may be canceled by either the provider or the department upon thirty days written notice prior to the termination date.

You are required to inform the department within thirty days of any changes to your provider information.

TN: 94-009
SUP:

Complete the Ohio Medicaid Organization Application/Agreement, attach required documentation, and mail to:

Provider Relations Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, Ohio 43266-0161

Should you have any questions regarding completion of your application/agreement form, call our Provider Enrollment Unit at:

In State 950-5627, after the dial tone, then dial 8-3288, press OPTION 2
Out of State (614) 728- 3288, press OPTION 2

Sincerely,

Wanda L. Ohler
Section Chief

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Attachment 4.16-I

Submit completed application/agreement to:
Provider Relations Section
Provider Enrollment Unit
P.O. Box 1461
Columbus, OH 43266-0161

(For State Use Only)

ODHS 6751 (Rev. 6/97)

Medicaid Provider Enrollment Application/Agreement for Organizations

Complete all applicable items if you plan to bill Medicaid as a sole proprietor of a business, or if you are a publicly or privately held business with more than one owner. (This does not apply to individual practitioners or practitioner groups.)

Organizational Provider Types: (Mark the ONE appropriate type)

- ☐ General Hospital (01)
- ☐ Mental Hospital (02)
- ☐ Outpatient Health Facility (04)
- ☐ Rural Health Facility (05)
- ☐ Federally Qualified Health Center (12)
- ☐ Hospice (44)
- ☐ Waivered Service Provider (45)
- ☐ Ambulatory Surgery Center (46)
- ☐ Comprehensive Clinic (50)
- ☐ PACE (08)
- ☐ Clinic-Mental, Drug, Alcohol (51)
- ☐ Public Health Department Clinic (52)
- ☐ Clinic-Rehabilitation (53)
- ☐ Planned Parenthood Clinic (54)
- ☐ Professional School Clinic-Optometry (55)
- ☐ Professional School Clinic-Dentistry (56)
- ☐ Diagnostic Clinic (58)
- ☐ Dialysis (59)
- ☐ Maternal Child Health Clinic (09)
- ☐ Home Health Agency (60)
- ☐ Pharmacy (70)
- ☐ Health Maintenance Organ. (77)
- ☐ Physiological Laboratory (79)
- ☐ Independent Laboratory (80)
- ☐ Portable X-ray Laboratory (81)
- ☐ Ambulance (82)
- ☐ Ambulette (83)
- ☐ Durable Medical Equipment (76)

Provider Identification: (Print or type entries)

Organization Name

Abbreviated Organization Name (If your name exceeds 30 spaces, indicate preferred abbreviation.)

Employer Identification Number __-_____

You must attach a signed W-9 form

Social Security Number (Proprietor) ___-___-____

ıgraphic Location:

Physical Location of Business (Applicants: If more than one location, list Primary.)

Building Name / or / Department / or / In care of

Business Address (Number, Street, Avenue, Route, etc: P.O. Boxes are not acceptable) | Suite Number

City | County | State | Zip Code (Zip +4, if possible)

Telephone Number (___) ___-____

Pay to" Address (Name & Address to which Payment or Remittance Advice is to be mailed)

Address is not different from "Physical Location of Business" address, leave blank)

uilding Name / or / Department / or / In care of

ddress | Suite Number

y | State | Zip Code (Zip + 4, if possible)

ailing/Correspondence Address (Name & Address to which all other material is to be mailed)

Address is not different from "Physical Location of Business" address, leave blank)

lding Name / or / Department / or / In care of

Suite Number

State | Zip Code (Zip + 4, if possible)

This Form May NOT Be Duplicated

(For State Use Only)

Medicare Identification Information: (Print or type entries)

PIN number*	PIN number*	DMERC number*

*You must attach copy or Department of Health and Human Services Approval Letter.

Clinical Laboratory Improvement Act Information (Print or type entries)

CLIA number*	CLIA number*	CLIA number*

* You must attach copy of CLIA Certificate * You must attach copy of CLIA Certificate * You must attach copy of CLIA Certificate

Remittance Advice:

I would like the claims listed on my Remittance Advice sorted by: **check ONE only**

☐ Recipient Name ☐ Recipient ID ☐ Transaction Control Number ☐ Medical Control Number

CD-ROM Capabilities:

Do you have CD-Rom capabilities? ☐ YES ☐ NO
Would you like to receive your handbooks and manuals on CD-ROM, as they become available? ☐ YES ☐ NO

Optional Categories of Service:

Check your Provider Type, and any other Optional Categories of Service you plan to provide.

Provider Type	Optional Category of Service
☐ Inpatient Hospital (01)	☐ Ambulance Services (37) ☐ Ambulette Services (38)
☐ Maternal Child Health Clinic (09)	☐ Passport Waiver III (66)
☐ Waiver (45)	☐ Private Duty Nursing Svcs (49)
☐ Comprehensive Clinic (50)	☐ Prescribed Drugs (30) ☐ Dental Services (45) ☐ Waivered Services (46) ☐ Optometric Services (47) ☐ Passport Waiver III (66)
☐ Ambulatory Surgical Center (46)	☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Mental, Drug, Alcohol Clinic (51)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip. (32) ☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Public Health Dept. Clinic (52)	☐ Prescribed Drugs (30) ☐ Dental Services (45) ☐ Waivered Services (46) ☐ Optometric Services (47) ☐ Passport Waiver III (66)
☐ Ambulance (82)	☐ Ambulette Services (38) ☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Ambulette (83)	☐ Waivered Services (46) ☐ Passport Waiver III (66)

Provider Type	Optional Category of Service
☐ Rehab Clinic (53)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32) ☐ Passport Waiver III (66)
☐ Planned Parenthood Clinic (54)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32) ☐ Passport Waiver III (66)
☐ Prof. School Clinic-Optometry (55)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32)
☐ Prof. School Clinic-Dental (56)	☐ Prescribed Drugs (30)
☐ Diagnostic Clinic (59)	☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Dialysis Clinic (59)	☐ Prescribed Drugs (30) ☐ Supplies & Med Equip (32) ☐ Passport Waiver III (66)
☐ Home Health Agency (60)	☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Pharmacy (70)	☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Durable Medical Equipment (76)	☐ Waivered Services (46) ☐ Passport Waiver III (66)
☐ Physiological Laboratory (79)	☐ Passport Waiver (66)
☐ Independent Laboratory (80)	☐ Passport Waiver (66)
☐ Independent X-ray Laboratory (81)	☐ Passport Waiver (66)

DEC. 1

TN No. 99-009 APPROVAL DATE _____

SUPERSEDES

TN No. 95-11 EFFECTIVE DATE 7/1/99

(For State Use Only)

Hospitals

Hospital License Number*	License Date (mm/dd/yyyy)	Current License Expiration Date* (mm/dd/yyyy)
	__/__/____	__/__/____

*You must attach copy of License

Hospital Bed Breakdown*

Bed Classification	Number of Beds	Bed Classification	Number of Beds
Medical/Surgical-Special Care	_____beds	Psychiatric	_____beds
Burn Unit	_____beds	Swing % of time used _____%	_____beds
Medical/Surgical-General	_____beds	Newborn Care	_____beds
Obstetrics-Level III	_____beds	Other_____	_____beds

TOTAL BEDS _____

*You must attach a copy of the letter from Department of Health with Your Bed Classification.

If you provide Pharmacy and/or Ambulance/Ambulette services you must, also, complete the Pharmacy and Transportation sections

Clinics *Check the applicable Clinic Type you are applying for, and attach a copy of the required documentation of Certification/Accreditation*

Ambulatory Health Care Clinic

Provider Type	Required documentation (to be submitted with application)
☐ 50 - Comprehensive Clinic	☐ Joint Commission of the Accreditation of Healthcare Organizations
☐ 51 - Mental Health, Drug, Alcohol	☐ Ohio Department of Health Recognition as an Alcoholism Outpatient and After-care Services Program. or, ☐ Ohio Department of Mental Health Certification as an Outpatient Mental Health Facility.
☐ 52 - Public Health Department Clinic	☐ Legal Status as a County Health Department, City Health Department, or Combined Health District
☐ 53 - Rehabilitation Clinic	☐ Commission on Accreditation of Rehabilitation Facilities. or, ☐ Medicare Certification as a Rehabilitation Clinic.
☐ 54 - Planned Parenthood Clinic	☐ Planned Parenthood Affiliation of America
☐ 59 - Dialysis Clinic	☐ Medicare Certification as a Dialysis Clinic
☐ 58 - Diagnostic Clinic	☐ Medicare Certification as a Diagnostic Clinic
☐ 55 - Professional School Clinic-Optometry	☐ Council on Optometry Education of the American Optometric Association.
☐ 56 - Professional School Clinic-Dentistry	☐ Council on Dental Education of the American Dental Association.

Note: Clinics that are in the receipt of "Health Services Block Grant Funds" under provision of Federal Law (e.g., Public Law 92-36) are also eligible for enrollment as an Ambulatory Health Care Clinic. The provider type assigned to such clinics should correspond to the types and scopes of services funded by the Block Grant.

Services Provided (Check **ALL** that apply)

☐ Prescribed Drugs	☐ Nursing	☐ Physical Therapy	☐ Supplies and Medical Equipment
☐ Waiver	☐ Laboratory	☐ Speech Therapy	☐ Other, Specify
☐ Optometric	☐ Psychology	☐ Family Planning	
☐ Physician	☐ Audiology	☐ Dental	

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